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In Reply Decision making on the use of oral anticoagulant treatment in patients with atrial fibrillation is often uncomplicated due to the positive risk-benefit ratio, ie, balancing risk of bleeding against benefit from thromboprophylaxis. Observational data on patients with atrial fibrillation sustaining an intracranial hemorrhage are increasing, recognizing the treatment conundrum of resuming oral anticoagulant treatment since the risk-benefit ratio of treatment is shifted substantially.

This is recognized in the Letter to the Editor by Hanley et al, but the authors also call for clarification on our contribution.[1] Specifically, they questioned if some studied patients were experiencing an initial ischemic stroke with a subsequent hemorrhagic transformation and were thus misclassified as having a spontaneous hemorrhagic stroke. Our registries did not hold imaging information, and the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision* do not allow for classification of ischemic stroke with hemorrhagic transformation. We acknowledge these facts as a limitation to our study. Even so, we included patients with atrial fibrillation with a subsequent diagnosis of intracranial hemorrhage using both primary and secondary coded diagnoses. The majority of patients included in the spontaneous hemorrhagic stroke group received a primary diagnosis (75%) of hemorrhagic stroke for the inclusion event. This signifies that this indeed was the principal reason for admission to the hospital. A minor subgroup of 29 patients were admitted to the hospital with a secondary diagnosis of hemorrhagic stroke and with a contemporary diagnosis of ischemic stroke. We cannot contribute further clarifying details on patients with a potential hemorrhagic transformation subsequent to an ischemic stroke because this would require imaging data with adjudicated outcomes certified by trained radiologists. Yet, it may seem very questionable that our findings are severely biased from misclassification.

Hanley et al also suggested including more variables as proxy markers for the severity of intracranial hemorrhage, eg, discharge to rehabilitation. We chose to retain our proxy marker for stroke severity to a single entity being days admitted to the hospital following the index event. While discharge to rehabilitation or home care nursing could also serve as markers for event severity, we believe such variables may be affected by other mediating parameters such as social status (living alone, etc). Indeed, selection of modeling covariates in observational studies is a delicate process where robustness, accuracy, and clear interpretation is a priority.

In the light of the observational nature of our data, strong recommendations on resumption of stroke prophylaxis following an intracranial hemorrhage event in patients with atrial fibrillation cannot be given.[2] Yet, these data may indicate that the decision if and when to resume warfarin treatment in this frail subgroup of patients has been safe.

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Conflict of Interest Disclosures: Dr Nielsen reports serving as a speaker for Boehringer Ingelheim, consulting for Bayer Pharma AG and Bristol-Meyers Squibb (BMS)/Pfizer, and receiving an unrestricted research grant from BMS/Pfizer. Dr Lip reports membership in and/or reviewing for various guidelines and position statements from the European Society of Cardiology, European Heart Rhythm Association, and National Institute for Health and Care Excellence, among others; serving on steering committees for various phase 2 and 3 studies, health economics, and outcomes research; serving as an investigator in various clinical trials in cardiovascular disease, including antithrombotic therapies in atrial fibrillation, acute coronary syndrome, and lipids; consulting for Bayer/Janssen, BMS/Pfizer, Biotronik, Medtronic, Boehringer Ingelheim, Microlife, and Daiichi-Sankyo; and serving as a speaker for Bayer, BMS/Pfizer, Medtronic, Boehringer Ingelheim, Microlife, Roche, and Daiichi- Sankyo. Dr Larsen reports serving as an investigator for Janssen Scientific Affairs, LLC, and Boehringer Ingelheim and on the speaker bureaus for Bayer, BMS/Pfizer, Roche Diagnostics, Boehringer Ingelheim, and Takeda Pharma. No other disclosures are reported.

1. Nielsen PB, Larsen TB, Skjøth F, Lip GYH. Outcomes associated with resuming warfarin treatment after hemorrhagic stroke or traumatic intracranial hemorrhage in patients with atrial fibrillation. *JAMA Intern Med*. 2017;177(4):563-570.

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CORRECTION

Error in Title: In the Research Letter titled "A National Survey of Medicaid Beneficiaries' Experiences and Satisfaction With Health Care,"[1] published online July 10, 2017, there was an error in the title: the word "Experiences" was misspelled as a different word. This article was corrected online.

1. Barnett ML, Sommers BD. A national survey of Medicaid beneficiaries' experiences and satisfaction with health care [published online July 10, 2017]. *JAMA Intern Med*. doi:10.1001/jamainternmed.2017.3174

Data Transcription Errors and Missing Footnote in Table: In the Research Letter titled "A National Survey of Medicaid Beneficiaries' Experiences and Satisfaction With Health Care,"[1] published online July 10, 2017, and corrected August 7, 2017, for an error in the title,[2] there were data transcription errors (not affecting conclusions) in the text, Figure caption, and Table. The Table was also missing a footnote, which should read "Standard errors were clustered by state and eligibility grouping." This article was corrected online.

1. Barnett ML, Sommers BD. A national survey of Medicaid beneficiaries' experiences and satisfaction with health care [published online July 10, 2017]. *JAMA Intern Med*. doi:10.1001/jamainternmed.2017.3174

2. Error in title [published online August 7, 2017]. *JAMA Intern Med*. doi:10.1001/jamainternmed.2017.4439

Incorrect Author Affiliation: In the article titled "Sharing Clinical Research Data—Finding the Right Balance,"[1] the affiliation for Steven N. Goodman, MD, PhD, was incorrect. Dr Goodman's correct affiliations are the Departments of Medicine and

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Health Research & Policy, Stanford University, Stanford, California. This article was corrected online.

1. Lo B, Goodman SN. Sharing clinical research data—finding the right balance [published online July 17, 2017]. *JAMA Intern Med*. doi:10.1001/jamainternmed.2017.1926

Sentence Added to Author Contributions: In the Original Investigation titled "Association of Ozone Exposure With Cardiorespiratory Pathophysiologic Mechanisms in Healthy Adults," published online July 17, 2017, in *JAMA Internal Medicine*,[1] a sentence was missing from the beginning of the Author Contributions section. The first 2 sentences now read: "Drs Y. Zhang and J. Zhang contributed equally and are considered co–senior authors of this work. In addition, they had full access to all the data in the study and take responsibility for the integrity of the data and accuracy of the data analysis." This article was corrected online.

1. Day DB, Xiang J, Mo J, et al. Association of ozone exposure with cardiorespiratory pathophysiologic mechanisms in healthy adults [published online July 17, 2017]. *JAMA Intern Med*. doi:10.1001/jamainternmed.2017.2842

Omitted Affiliation and Disclaimer: In the Research Letter titled "Inclusion of Demographic-Specific Information in Studies Supporting US Food & Drug Administration Approval of High-Risk Medical Devices,"[1] published online July 24, 2017, a journal affiliation for author Ross was omitted: Dr Ross is Associate Editor of *JAMA Internal Medicine*. In addition, the disclaimers for authors Ross and Redberg were omitted: **Disclaimer:** Dr Ross is Associate Editor of *JAMA Internal Medicine*, and Dr Redberg is Editor of *JAMA Internal Medicine*, but neither author was involved in any of the decisions regarding review of the manuscript or its acceptance. This article was corrected online.

1. Dhruva SS, Mazure CM, Ross JS, Redberg RF. Inclusion of demographic-specific information in studies supporting US Food & Drug Administration approval of high-risk medical devices [published online July 24, 2017]. *JAMA Intern Med*. doi:10.1001/jamainternmed.2017.3148.

Caution Advised for Readers of Letters Related to Retracted Articles: Two Original Investigations, "The Prevention of Hip Fracture With Risedronate and Ergocalciferol Plus Calcium Supplementation in Elderly Women With Alzheimer Disease: A Randomized Controlled Trial," and "Risedronate Sodium Therapy for Prevention of Hip Fracture in Men 65 Years or Older After Stroke," were retracted on June 3, 2016.[1,2] A series of Letters[3-6] were written to comment on the originally published articles and were published before the Retraction notice. This formal Correction notice is published to alert readers and remind them to not rely on the subsequently retracted articles.

1. Bauchner H, Redberg RF. Notice of retraction: Sato Y, et al. The prevention of hip fracture with risedronate and ergocalciferol plus calcium supplementation in elderly women with Alzheimer disease: a randomized controlled trial. *Arch Intern Med*. 2005;165(15):1737-1742. *JAMA Intern Med*. 2016;176(9):1256. doi:10.1001/jamainternmed.2016.3177

2. Bauchner H, Redberg RF. Notice of retraction: Sato Y, et al. Risedronate sodium therapy for prevention of hip fracture in men 65 years or older after stroke. *Arch Intern Med*. 2005;165(15):1743-1748. *JAMA Intern Med*. 2016;176(9):1256. doi:10.1001/jamainternmed.2016.3771

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